Millcreek Family Dental
1455 So. 500 W. Suite D
Bountiful, Utah 84010
801-292-4009

Information for Patients with Dental Insurance

This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance plan.

It is in your best interest to personally confirm that Dr. Baird is a provider for your particular insurance plan. Although Dr. Baird may be a provider for your insurance company, he may not be a provider for every single plan that your insurance company offers.

Most insurance companies will verify with us that you have dental coverage, and some will give us a small list of what your coverage is. However, they do not provide to our office a full breakdown of all your benefits.

We will do our very best to calculate as closely as possible what your insurance plan will pay for a procedure or treatment, so you will know in advance **approximately** how much additional you may need to pay over and above what your insurance will cover.

PRINT NAME **SIGNATURE** **DATE**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective July 2014

Name: _____ Date of Birth: _____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised version, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give permission for this service.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

2 Step *Please Read, Health Questionnaire and Acknowledgement with Consent to Proceed:*

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Anthony J. Baird and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

3 Step *Please Sign Below*

Signature of Patient, Parent or Guardian	*Date*	*Relationship to patient*
Signature of Witness	*Date*	

4 Step *Review of Medical History*

I have reviewed the foregoing Medical History (other side) and find it to be unchanged and accurate, except as noted

Signature of Patient, Parent or Guardian	*Date*	*Updated Information*
		Signature of Dentist
Signature of Patient, Parent or Guardian	*Date*	*Updated Information*
		Signature of Dentist
Signature of Patient, Parent or Guardian	*Date*	*Updated Information*
		Signature of Dentist

MILLCREEK
— FAMILY DENTAL —

ANTHONY J. BAIRD, DDS

Patient Name

292-4009

1455 SOUTH 500 WEST - SUITE D
BOUNTIFUL, UTAH 84010

1 Step *Please Read, and Answer the Following Questions, Medical History Form*

Yes No

☐ ☐ 1. Are you having pain or discomfort at this time?
☐ ☐ 2. Do you have or have you ever had bleeding or sensitive gums?
☐ ☐ 3. Do you feel nervous about having dental treatment?
☐ ☐ 4. Have you been hospitalized during the past two years?
☐ ☐ 5. Have you been under the care of a medical doctor during the past two years?
Physician's Name _____ Type of Practice _____
Address _____ Phone _____
☐ ☐ 6. Have you taken any medication or drugs during the past two years?
☐ ☐ 7. Are you now taking any medication, drugs or pills?
If yes, please list: _____
☐ ☐ 8. Are you allergic or have you reacted adversely to any of the following?

☐ Aspirin ☐ Erythromycin ☐ Sulfa Drugs ☐ Barbiturates
☐ Codeine ☐ Penicillin ☐ Latex ☐ Do you have any other allergies?
☐ Nitrous Oxide ☐ Other Antibiotics ☐ Ibuprofen If yes, please list. _____
☐ Tetracycline ☐ Local Anesthetic ☐ Acetaminophen _____

9. Check any of the following, which you HAVE HAD OR HAVE at present:

☐ Heart Failure ☐ Emphysema ☐ A.I.D.S. or H.I.V.
☐ Heart Disease or Attack ☐ Cough ☐ Hepatitis A (infectious)
☐ Angina Pectoris ☐ Tuberculosis (TB) ☐ Hepatitis B (serum)
☐ High Blood Pressure ☐ Asthma ☐ Hepatitis C
☐ Heart Murmur ☐ Hay Fever ☐ Liver Disease
☐ Rheumatic Fever ☐ Sinus Trouble ☐ Yellow Jaundice
☐ Congenital Heart Lesions ☐ Allergies or Hives ☐ Blood Transfusion
☐ Scarlet Fever ☐ Diabetes ☐ Hemophilia
☐ Heart Pacemaker ☐ Thyroid ☐ Fever Blisters
☐ Heart Surgery ☐ X-ray or COBALT Treatment ☐ Epilepsy or Seizures
☐ Artificial Joints (Hip, Knee) ☐ Chemotherapy (Cancer, Leukemia) ☐ Fainting or Dizzy Spells
☐ Anemia ☐ Arthritis ☐ Nervousness
☐ Stroke ☐ Rheumatism ☐ Psychiatric Treatment
☐ Kidney Trouble ☐ Cortisone Medicine ☐ Sickle Cell Disease
☐ Ulcers ☐ Glaucoma ☐ Bruise Easily
☐ Cosmetic Surgery ☐ Pain in Jaw Joints ☐ Venereal Disease
☐ Drug Addiction ☐ Cold Sores ☐ Other _____

☐ ☐ 10. When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you are very tired?
☐ ☐ 11. Do your ankles swell during the day?
☐ ☐ 12. Do you use more than 2 pillows to sleep?
☐ ☐ 13. Are you on a special diet? If so, please explain _____
☐ ☐ 14. Have you ever taken Phen-Fen or similar appetite suppressants? If Yes, have you seen your physician or cardiologist for a cardiac evaluation?____
☐ ☐ 15. Do you have any disease, condition, or problem not listed? _____
☐ ☐ 16. Have you visited a dentist in the past year? Date of last dental visit _____
☐ ☐ 17. **FOR WOMEN ONLY:** ARE YOU PREGNANT? If yes, what month _____
☐ ☐ 18. **FOR WOMEN ONLY:** Are you taking birth control pills?

_____ _____ _____
Signature of Patient, Parent or Guardian *Date* *Relationship to Patient*

I hereby certify that the answers to the above questions are accurate to the best of my knowledge.

4 Step — *Getting to Know You*

Referred to us by? or, How did you hear about Millcreek Family Dental?

Your Hobbies and Interests

Is a member of your family a patient in our office? ☐ Yes ☐ No

Their Name

Address City State Zip

5 Step — *Emergency Contact Information*

Name of an individual you would like us to contact in an emergency?

Address City State Zip

Home Phone # Work Phone # Ext #

Closest Relative NOT living with you?

Address City State Zip

Home Phone # Work Phone # Ext #

6 Step — *Please Read, Office Policies and Federal Truth-in-Lending Statement*

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

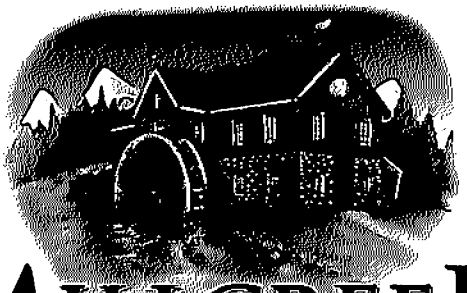
In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Anthony J. Baird D.D.S. I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined there in.

7 Step — *Please Sign Below*

Signature of Patient, Parent or Guardian | *Date* | *Relationship to patient*



MILLCREEK
— FAMILY DENTAL —

ANTHONY J. BAIRD, DDS

FAMILY DENTISTRY
Crowns
Bridges
Porcelain Fillings
Oral Surgery
Root Canals

COSMETIC DENTISTRY
Whitening / Bleaching
Porcelain Veneers
Cosmetic Bonding & Reconstruction

292-4009

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BOUNTIFUL, UTAH 84010

Please Complete the Following Patient Registration and Confidential Health History

1 Step — If the appointment is for YOU. Please Start Here.

Today's Date

Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Work Phone # | Cell or Pager # *(if applicable)*

Drivers Licence # | Birth Date | SS#

☐ Single ☐ Married ☐ Divorced ☐ Widowed | E-Mail Address

2 Step — *Insurance Information*

Group #

Dental Insurance Company | Phone #

Street Address

City | State | Zip Code

Employer | Phone #

Insured Employee Name | Birth Date

Date Employed | Insured Employee SS#

1 Step — If the appointment is for your CHILD. Please Start Here.

Today's Date

Child's Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Birth Date | Age

School | Grade

3 Step — *Person Financially Responsible for Account*

Name

Address | City | State | Zip

Home Phone # | Work Phone # | Ext #

SS# | Drivers License #

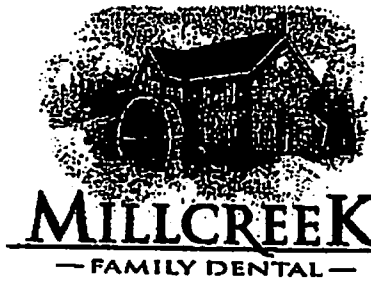
Employer | Work Phone # | Ext #

Work Address | City | State | Zip

Spouse's Name

Employer | Work Phone # | Ext #

Work Address | City | State | Zip



Dr. Anthony J. Baird
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We would like to confirm your future appointments through Text, E-mail or a phone call. None of the information you provide will be used for any other reason.
Which do you prefer?

Print Patients Name_____

Preferred____Text Phone # ( )_____

Preferred____E-Mail (Print Clearly)_____

Preferred____Phone Call # ( )_____

Is this information good to use for ALL family members? Yes or No

If you choose Text, you must "opt in" to the service. We do not charge you for this service, but you must tell us it is okay to text you. You will receive a text from us stating that Dr. Baird offers text messaging. You will be asked to press Y to opt in. In the future you can confirm your appointments by following the prompts with text or with E-mail.